DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 4/23/11

PRINTED: 03/11/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445491	A. BUILDING ______ B. WING ______	03/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCKENDREE VILLAGE INC	4347 LEBANON ROAD HERMITAGE, TN 37076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure one resident (#17) was assessed prior to self administration of a medication of twenty-six residents reviewed. The findings included: Resident #17 was admitted to the facility on January 31, 2011, with diagnoses including Anxiety State, Joint Replaced Hip, and Depressive Disorder. Medical record review of Physician's Recapitulation orders dated March 4, 2011, revealed, "...Albuterol...nebulizer tx (treatment) every morning..." Observation of resident #17 in the resident's room on March 7, 2011, at 10:35 a.m., revealed a nebulizer mask placed around the resident's nose and mouth; the nebulizer machine in the on position; and no facility staff in the room or in line of site outside the room. Interview with Charge Nurse # 3 at the north hall nurse's desk, on March 7, 2011, at 11:35 a.m., confirmed the charge nurse had attached the nebulizer mask; turned the nebulizer machine to	F 176	This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction (PoC) does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. F 176 Resident Self administer drugs, if deemed safe: 1. Resident # 17 no longer resides in the facility. 2. The interdisciplinary team has completed assessments on other residents who receive nebulizer treatments for safe practice of self-administration. 3. Nursing staff inservices are being conducted by the Director of Nursing or her designee and will be completed by March 29th, regarding the facility's policy & procedure on the safe practice of self-administration of nebulizer treatments. 4. The Director of Nursing or her designee will randomly monitor three (3) times weekly for four (4) weeks residents who have been assessed by the interdisciplinary team to safely self-administer nebulizer treatments. The Director of Nursing will report findings during the monthly Performance Improvement (QA) meeting. The Performance Improvement (QA) Committee includes the Medical Director, Administrator, Director of Nursing, Social Services Director, Nurse Managers, Housekeeping Supervisor, Maintenance Representative, Admissions Coordinator, Medical Records Representative, and representatives from other departments, as necessary. Completion date	April 7, 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Fred R. Levoy FRED R. LEVOY	Administrator	March 23, 2011

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 176	Continued From page 1 the on position, placed the Albuterol inside the plastic cylinder attached the nebulizer mask and left the room. Continued interview at this time confirmed the resident had not been assessed for self administration of medications prior to self administration.	F 176	F226 Implementation of Abuse policy. 1. The Director of Nursing and the Rehab Director completed a thorough investigation of the alleged verbal abuse reported by Resident #13. This review was completed on March 10th, and included record review and interviews with individuals involved.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, and interview, the facility failed to implement the abuse policy after an allegation of verbal abuse for one resident (#13); and failed to complete an investigation for injury of unknown origin immediately for one resident (#16) of twenty-six residents reviewed. The findings included: Resident #13 was admitted to the facility on February 11, 2011, with diagnoses of History of Falls, Acute Kidney Failure, and Asthma. Medical record review of the Minimum Data Set dated February 18, 2011, revealed the resident was able to perform interview. Interview with resident #13 on March 8, 2011, at 9:00 a.m., in the resident's room, revealed the resident complained a PTA (physical therapy assistant) had been verbally abusive.	F 226	2. The facility staff followed its abuse policy & procedure and suspended the PTA (Physical Therapy Assistant) who was alleged to have been involved in the incident involving Resident #13. This individual, who was not an employee, but a facility contractor, was immediately suspended from work and excluded from any contact with facility residents pending the outcome of the investigation. 3. The Director of Social Services or her designee have begun random resident interviews and will complete these interviews by March 31st. These interviews are a preventative measure that the facility is taking in a proactive effort to identify other possible unreported allegations of verbal abuse, should any exist. The Director of Social Services will conduct inservice training for the facility staff in all departments on the facility's policy & procedure regarding allegations of abuse and reporting requirements by March 29th. For staff members who are unable to attend due to leave, vacation, et cetera, training will be provided upon their return to work. 4. The Director of Social Services will report the findings of the random interviews during the monthly Performance Improvement (QA) meeting. The Performance Improvement (QA) Committee includes the Medical Director, Administrator, Director of Nursing, Social Services Director, Nurse Managers, Housekeeping Supervisor, Maintenance Representative, Admissions Coordinator, Medical Records Representative, and representatives from other departments, as necessary. Completion date	March 31, 2011

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F 226	Continued From page 2 Interview with CNA#2 (certified nursing assistant) on March 8, 2011, at 2:10 p.m., in the hallway, confirmed had overheard PTA had made harsh remarks to the resident. Continued interview revealed CNA #2 had seen the resident crying immediatley after the incident and had to comfort the resident. Further interview revealed the CNA had reported the allegation to the nurse at the time of the incident. Review of the facility's policy Preventing Resident Abuse, revealed "...(i.)monitoring staff on all shifts to identify inappropriate behavior toward resident ..." Interview with the Administrator and Social Services on March 8, 2011, at 2:45 p.m., in the Administrator's office, confirmed had no knowledge of any allegation and verified no verbal allegation had been investigated. Resident # 11 was admitted to the facility July 25, 2006, with diagnoses including Senile Dementia, Alzheimer's Disease, Congestive Heart Failure, Hypertension, Osteoarthritis, Joint Pain and Bone/Cartilage Disorder. Medical record review of the Minimum Data Set dated November 10, 2010, revealed the resident had long and short term memory problems, severe cognitive impairment, was non-ambulatory, required extensive assistance with bed mobility, and two person physical assistance with transfers. Medical record review of the nurse's note dated	F 226	F226 (continued) 1. The Director of Nursing completed a thorough investigation of the ankle injury of unknown origin as a possible instance of abuse to Resident #11. Additional investigation of this unusual incident by the Director of Nursing did not reveal any conclusive cause of the injury. 2. From the investigation, it could not be readily determined how the ankle injury occurred. Therefore, an instance of abuse was not identified and actions that were taken under the circumstances were deemed to be appropriate. 3. Random resident interviews will be completed by the Director of Social Services or her designee by March 31st in an effort to identify other possible incidents involving abuse. The Director of Social Services will conduct inservices for the facility staff on the facility's policy & procedure regarding allegations of abuse and reporting requirements by March 29th. 4. The Director of Social Services will report the findings of the random interviews during the monthly Performance Improvement (QA) meeting. The Performance Improvement (QA) Committee includes the Medical Director, Administrator, Director of Nursing, Social Services Director, Nurse Managers, Housekeeping Supervisor, Maintenance Representative, Admissions Coordinator, Medical Records Representative, and representatives from other departments, as necessary. Completion date	April 7, 2011

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F 226	Continued From page 3 January 30, 2010, revealed at 8:15 a.m. "...Left ankle noted to be very swollen-unable to fit shoe on, also outer aspect of ankle bruised-blue in color. Tender to touch..." at 8:30 a.m. "...Dr (name) notified of L (left) ankle swelling & (and) bruising, order rec'd (received) for X-ray-(name) X-ray notified..." at 8:40 a.m. "...POA (Power of Attorney) made aware of ankle condition & new order-to be here to see resident this pm..." at 12:00 p.m. "... Spoke with DPOA (Durable Power of Attorney) about pt. (patient) Will notify DPOA when X-ray arrives..." at 6:30 p.m. "... X-ray report called to Dr (name) & order rec'd for Ace wrap & ice packs as tol. (tolerated)...Nurse manager to notify DPOA..." Medical record review of left ankle X-ray report dated January 30, 2011, revealed " ...Fracture:None, extensive soft tissue swelling ..." Continued medical record review of the nurse's note dated February 3, 2011, at 11:20 a.m. revealed " ...Resident c/o (complaint of) pain in L foot, ankle. Dr (name) notified and orders rec'd. DPOA notified ..." Medical record review of the left ankle X-ray report dated February 3, 2011, revealed "...Minimally displaced fracture through the tip of the lateral malleolus (ankle bone), Bone mineralization: Osteopenic (reduced bone mass below normal level)..." Review of facility records revealed the facility began an investigation of the injury of unknown origin on February 3, 2011 (four days after the ankle injury was discovered). Further review of the investigation revealed the facility only interviewed the staff who were responsible for the	F 226		

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F 226	Continued From page 4 care of the resident on January 30, 2011. No interviews of staff caring for the resident prior to that date were conducted. Interview with Director of Nursing #2, on March 9, 2011, at 9:15 a.m., in the conference room confirmed the facility failed to conduct a complete investigation of the injury of unknown origin. c/o27666	F 226		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide pressure relieving device for two residents (#5, #15) and failed to assess a wound timely for one resident (#5) of twenty-six residents reviewed. The findings included: Resident #5 was admitted to the facility on February 10, 2011, with diagnoses including Rehabilitation Services, Aftercare for Hip Replacement, Diabetes, and Hypertension.	F 314	F 314 Treatment/Svcs to prevent/heal pressure sores: 1. A pressure relief mattress was immediately placed on Resident # 5's bed. Resident #5 has been reassessed per policy. 2. All residents with pressure ulcers have been audited to determine assessments are completed per policy. Residents with interventions of pressure relief mattresses were assessed by the Director of Nursing or her designee. 3. The Director of Nursing or her designee will inservice nursing staff regarding pressure relief mattresses by March 29th. A new "Nursing Admission Assessment" form has been implemented which includes measurements at the time of admission when patients are admitted with wounds. 4. The Director of Nursing, Unit Managers, or designee will monitor residents with skin integrity interventions - pressure relief mattresses - weekly until compliance is achieved. The Director of Nursing will report findings during the monthly Performance Improvement (QA) meeting. The Performance Improvement (QA) Committee includes the Medical Director, Administrator, Director of Nursing, Social Services Director, Nurse Managers, Housekeeping Supervisor, Maintenance Representative, Admissions Coordinator, Medical Records Representative, and representatives from other departments, as necessary. Completion date	April 7, 2011

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F 314	Continued From page 5 Medical record review of the nursing admission assessment dated February 10, 2011, revealed a wound on the coccyx area. The documentation revealed no description or assessment of the wound. Review of the weekly skin assessment record dated February 10, 2011, revealed a check for alteration in skin integrity with no description of the wound on coccyx. Continued review of the next weekly skin assessment revealed was February 24, 2011, (14 days). The documentation did not reveal description or any type of measurement of the wound. Medical record review of the Braden Scale (for predicting pressure sore risk) dated February 10, 2011, revealed a score of 14, (score of 12 or less represents high risk). Medical record review of the treatment record dated February, 2011, revealed the treatment to the coccyx was to be cleanse buttocks with normal saline, pat dry, cover with 4 x4 allevyn adhesive, change every three days and as needed. Continued review of the treatment record dated February 2011, revealed the resident's treatment to the coccyx was changed on February 16, 2011, to cleanse buttocks with normal saline, pat dry, apply nystatin powder every shift. Medical record review of the nursing daily summary dated February 17, 2011, revealed "open areas noted to the coccyx." Continued review revealed nursing summary notes dated February 24, 2011, revealed "buttocks red with three small open areas." Review of the documentation revealed no description or measurement of the open area on the buttocks. Medical record review of the weekly pressure	F 314	F 314 (continued) 1. Resident #15 was reassessed during the survey and an order clarification was received for posey boots, which were the pressure relieving device of choice and were already in place on both of the patient's heels. 2. All residents with pressure ulcers have been audited to determine assessments are completed per policy. Residents with interventions of pressure relieving devices were assessed by the Director of Nursing or her designee. 3. The Director of Nursing or her designee will inservice nursing staff regarding pressure relieving devices by March 29th. A new "Nursing Admission Assessment" form has been implemented which includes measurements at the time of admission when patients are admitted with wounds. 4. The Director of Nursing, Unit Managers, or designee will monitor residents with skin integrity interventions - pressure relieving devices - weekly until compliance is achieved. The Director of Nursing will report findings during the monthly Performance Improvement (QA) meeting. The Performance Improvement (QA) Committee includes the Medical Director, Administrator, Director of Nursing, Social Services Director, Nurse Managers, Housekeeping Supervisor, Maintenance Representative, Admissions Coordinator, Medical Records Representative, and representatives from other departments, as necessary. Completion date	April 7, 2011

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F 314	Continued From page 6 ulcer record dated March 3, 2011, revealed the pressure ulcer was staged at a three and gave one measure of 3.0 x0.9x 0.2 cm (centimeters). Further review revealed the intervention was to be a pressure relieving mattress. Observation with the Treatment Nurse on March 8, 2011, at 10:35 a.m., in the resident room, revealed two open areas on the resident's coccyx and the Treament Nurse continued to stage the pressure ulcer as a three. The measurements for (1) open area 1.1x 1.3x 0.1, second open area measurement was 3.4x 0.05x 0.1 cm., Treament Nurse stated pressure ulcer had blood tinged drainage. Continued observation revealed no pressure relieving mattress was in place. Interview with the Unit Manager of Two North, on March 9, 2011, at 7:40 a.m., at the nurses' station, confirmed an initial assessment of the pressure ulcer with description and measurement of ulcer on the coccyx was not completed at the time of admission, and the initial assessment of the pressure ulcer with the measurements was not completed until March 3, 2011. Continued interview with the Unit Manager confirmed the lapse of fourteen days between the "weekly" skins assessments. Further interview confirmed the intervention of pressure relieving device was not in place. Resident #15 was admitted to the facility on November 15, 2010, with diagnoses including Compression Fractures, Difficulty in Walking, Pressure Ulcer Lower Back, Pressure Ulcer	F 314		

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F 314	Continued From page 7 Stage One, and Dementia. Medical record review of a Physician Consultation Request and Response dated December 9, 2010, revealed "...Recommendations...apply Multipodus boots B/L (bilateral)-No pressure to B/L heels..." Medical record review of the Weekly Wound Care Plan dated December 8-29, 2010, revealed "...Float heels et (and) posey boots, as pt (patient) allows..." Medical record review of a Physician's Telephone Order dated March 9, 2011, revealed "...May substitute Posey boots for Multi-podus boots effective December 9, 2010..." Medical record review of the Weekly Pressure Ulcer Record dated March 3 and 9, 2011, revealed the resident had an unstageable open wound on the resident's left heel of the foot. Observation with the Wound Treatment Nurse, on March 9, 2011, at 10:00 a.m., in the resident's room, revealed resident #15 to have a round-shaped wound on the heel of the left foot which measured 1.3cm (centimeter) by 1.2cm. Observation on March 9, 2011, at 7:20 a.m., in the second floor dining area, in front of the nurse's station, revealed the resident sitting in a wheelchair at the dining table with no pressure relieving boots on the resident's feet. Observation and Interview on March 9, 2011, at 7:27 a.m., with Licensed Practical Nurse (LPN) #1 confirmed the resident did not have the pressure relieving boots in place.	F 314		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=G	Continued From page 8 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview, the facility failed to supervise and insure safety devices was in place for one resident (#19) of twenty-six residents reviewed. The facility's failure to ensure safety devices were in place resulted in a fall and harm for resident #19. The findings included: Resident #19 was admitted to the facility on January 12, 2011, with diagnoses including Personal History of Fall, Chronic Kidney Disease, Difficulty Walking, and Lack of Coordination. Medical record review of the resident's Care Plan dated January 12, 2011, revealed, "...Problem...resident is at risk for falls...Goal resident will not sustain any significant injuries r/t (related to) fall...Intervention...Bed/Chair alarm..." Medical record review of a nurse's note dated February 16, 2011, revealed "...resident found in floor with head laceration..." Continued review of	F 323	F 323 Free of Accident Hazards/ Supervision/ Devices 1. The safety alarm was immediately placed on Resident #19's chair on February 16th following her return from the Emergency Room. 2. Other residents with safety alarms were immediately assessed to insure proper placement of functioning safety alarms. 3. The nursing department and therapy department staff will be inserviced by the Director of Nursing and/or Rehab Department Director or designee by March 29th regarding the facility's policy & procedure for placement of safety alarms. 4. The Director of Nursing, Unit Managers, or designee will monitor placement of safety alarms three (3) times per week for three (3) weeks, two (2) times per week for two (2) weeks, one (1) day per week for one (1) week, and randomly thereafter. The Director of Nursing, Unit Managers, or designee will report findings during the monthly Performance Improvement (QA) meeting. The Performance Improvement (QA) Committee includes the Medical Director, Administrator, Director of Nursing, Social Services Director, Nurse Managers, Housekeeping Supervisor, Maintenance Representative, Admissions Coordinator, Medical Records Representative, and representatives from other departments, as necessary. Completion date	April 7, 2011

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F 323	Continued From page 9 a hospital emergency report dated February 16, 2011, revealed, "...fall lac (laceration) to forehead...procedure performed...laceration repair <30 cm (centimeters)..." Medical record review of a nurse's note dated February 16, 2011, at 9:00 p.m., revealed "returned from...ER (emergency room) 3 (three) stitches noted to forehead..." Review of the facility policy for Falls Clinical Protocol Treatment/Management revealed "...Based on...assessment, the staff...will identify pertinent interventions to try to prevent subsequent falls..." Interview and review of the facility investigation with Charge Nurse #2 on March 8, 2011, at 4:12 p.m., in the north wing dining room, confirmed the resident had returned from therapy and the alarm was not reapplied prior to the fall that occurred on February 16, 2011, resulting in a fall and harm.	F 323		